WEBSTER FAMILY PHYSICIANS, P.C.
7979 BIG BEND BOULEVARD
WEBSTER GROVES, MISSOURI 63119
314-961-6631

Dear New Patient,

Welcome to our practice and thank you for allowing us to serve your medical needs. We are providing the following information to ensure a smooth transition into our practice.

Please complete the enclosed forms and bring them with you to your first appointment. Please arrange to have all recent bloodwork and imaging results as well as relevant medical records sent to our office before your appointment or bring them with you that day. Plan to arrive ten minutes early to your appointment so that we can have your chart ready.

If your health history is long and complicated, please provide a written timeline of your health events: major illnesses, hospitalizations, surgeries, and new diagnoses, in the order in which they occurred. This will help our providers gain an overview and make your time with us more productive. Email to office@websterfp.com would be best, so what you write can easily be incorporated into your electronic medical record, but also in paper format, to be able read easily during the visit. You may use the form included in the packet.

Office Policies

•Payment is expected at the time of your visit. We do not accept any insurance plans but will submit the claim to your insurance. Please bring photo identification and your current insurance card. We accept cash, check, Master Card, and Visa.

•If you need to cancel or reschedule your appointment, please notify our office by phone by 3:00 p.m. the prior business day. For appointments cancelled after this or missed, a missed appointment fee of $100 for new patients and $45 for existing patients applies.

•Consultations outside of regularly scheduled office or telemedicine visits, either submitted directly through the patient portal or relayed by telephone through the front office, will result in a charge. This includes requests for care and consultation

- submitted through the patient portal
- relayed by telephone through the front office
- made during nights and weekends through the answering service.

Charges will be based on the time required of the practitioner, and on the same scale as office and telemedicine visits. For those with traditional Medicare, a lower fee schedule applies.

There is no charge for the following services:

- simple clarification questions on care recently rendered
- our notes on lab and imaging results that were ordered at a recent scheduled visit
- regular prescription refills up to 12 months since the last scheduled visit
- controlled substance refills up to 3 months since the last scheduled visit, after which time another such visit would be needed.

Thank you for choosing us as your health provider. We look forward to working with you.

Sincerely,

Christian Wessling, MD
Cindy Willbrand

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I acknowledge that I have received notice of the above office policies.

Name: _____ Date: _____

WEBSTER FAMILY PHYSICIANS, P.C.

7979 Big Bend Blvd
Webster Groves, MO 63119
Tel: 314-961-6631
Fax: 314-961-4796

Privacy Practices Acknowledgement

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) I have received the Notice of Privacy Practices and I have been provided opportunity to review it.

PATIENT NAME: _____

PATIENT DOB: _____

SIGNATURE: _____

DATE: _____

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Medication History Consent

I give my consent for my medication record to be sent electronically to Webster Family Physicians P.C. These are records obtained from pharmacies through EMR (electronic medical records) systems.

SIGN: _____

DATE: _____

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I, _____, give permission to Webster Family Physicians to speak to the following person (s) about my medical information.

Patient Signature: _____

Date: _____

Name: _____

Name: _____

Name: _____

Name: _____

Health History Questionnaire

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

PATIENT NAME: _____

DATE OF BIRTH: _____

ALLERGIES
List any allergies to medications, food, insects, etc

1) 2)

3) 4)

5) 6)

MEDICATIONS/SUPPLEMENTS
List any medications or supplements, please include medication strength and frequency

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you have any of the following problems?

____ Acid Reflux
____ Alcoholism/other addictions
____ Allergies (environmental)
____ Anxiety
____ Asthma
____ Atrial fibrillation
____ Cancer
____ Coagulation (blood or clotting) problem
____ Diabetes mellitus
____ Erectile dysfunction
____ Heart disease
____ Hypertension/High Blood Pressure
____ IBS
____ Migraines
____ Thyroid Problem
____ Chronic low back pain
____ Depression
____ Other problems: _____

FAMILY HISTORY **Medical Condition**	**Relation** (Mother, Father, Sibling, Paternal/Maternal Grandparents, Aunt/Uncle)
Alcoholism	
Arthritis	
Depression	
Cancer	
Diabetes	
Genetic disease	
Heart Disease	
Hypertension	
Osteoporosis	
Stroke	

_____ I do not know my family history
_____ No medical issues

SOCIAL HISTORY

Tobacco
Do you use tobacco?
____ Yes ____No ____Never If yes – frequency or years of past use: _____

Caffeine
____ None ____ Occasional ____Moderate ____ Heavy

Alcohol
____ Yes ____ No If yes – how many drinks per week/month? _____

Drugs
Use of recreational or street drugs
____ Yes ____ No If yes, list: _____

Education
Less than 8th Grade High School 2-year college 4-year college Postgraduate

Marital Status
____ Married ____ Single ____ Divorced
____ Separated ____ Widowed ____ Domestic Partner

SURGICAL HISTORY Please list all prior operations and dates (month/year or year only is acceptable)	
Operation	**Date**

_____ I have had no prior surgery

Timeline of Medical History

Please list any major illness, medical events, hospitalizations, surgeries or new diagnoses in order in which they occurred.

Date **Event**

_____ _____

_____

Date **Event**

_____ _____

_____

Date **Event**

_____ _____

_____

Date **Event**

_____ _____

_____

Date	Event
Date	Event
Date	Event
Date	Event
Date	Event
Date	Event
Date	Event

Authorization to Use or Disclose My Health Care Information

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

My Authorization for: (doctor) _____

Address/Phone _____

You may use or disclose the following health care information (check all that apply):

( ) All health care information in my medical record
( ) Health care information in my medical record relating to he following treatment or condition:

_____

( ) Health care information in my medical record for the dates: _____
( ) Other (e.g., Xrays, bills), specify dates: _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

( ) HIV (AIDS virus)
( )Psychiatric disorders/mental health
( ) Sexually transmitted disease
( )Drug and/or alcohol use

You may disclose this healthcare information to:

Webster Family Physicians, P.C.
7979 Big Bend Blvd.
Webster Groves, MO 63119
PH: 314-961-663
FAX: 314-961-4796

Christian Wessling, M.D.

Reason(s) for this authorization (check all that apply): ( ) consultation ( ) changing physicians
( ) other (specify): _____

This authorization ends: ( ) 90 days from date signed
( ) On (date) _____
( ) When the following event occurs _____
(no longer than 90 days from date signed)

My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in research study
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Webster Family Physicians, P.C. based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from Webster Family Physicians, P.C.
- Write a letter to Webster Family Physicians P.C.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws no longer protect it.

_____ _____ _____
Patient or legally authorized individual signature | Date | Time

_____ _____
Printed name if signed on behalf of the patient | Relationship (parent, legal guardian, personal representative, etc)